Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

St. Mary Behavioral Pain Management
3033 Fannin Street
Houston, Texas 77004

Respondent Name

Fidelity & Guaranty Insurance Company

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-2407-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Fee Guidelines"

Amount in Dispute: $3,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this dispute.

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 12, 2008 June 13, 2008 June 17, 2008	CPT code 97799 CP, 8 hours X 3 DOS	$3,000.00	$2,400.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the rules for preauthorization.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 11, 2008

   - W9 – UNECESSARY MED TREATMENT BASED ON PEER REVIEW. PEER REVIEW OBTAINED BY THE CARRIER IND TREATMENT TO BE MEDICALLY UNREASONABLE AND/OR UNNECESSARY AND DOCUMENTED SERVC DOES NOT MEET THE FEE GUIDE CONTAINED W/ APPLI AMA CPT/HCPCS GUIDE

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. Per Texas Labor Code, Section §413.011(b) "the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 Texas Administrative Code, Section §133.240(b) states, "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of the title (relating to Benefits—Guidelines for Medical Services, Charges, and Payments." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any heath health care listed in subsection (p) of this section was approved prior to providing the health care." 28 Texas Administrative Code, Section §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letter dated May 7, 2008 supports the provider obtained preauthorization for the disputed services prior to providing the health care.
2. Per 28 Texas Administrative Code, Section §134.204(h), a chronic pain management program shall be $125.00 per hour for a CARF accredited program. A CARF accredited program is indicated by using the modifier –CA. The requestor did not provide the CARF accredited modifier; therefore, the monetary value of the program will be 80% of the CARF accredited value. CPT code 97799-CP will be reimbursed at $100.00 x 8 hrs = $800.00 X 3 DOS = $2,400.00. This amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $2,400.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,400.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order..

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 8, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.